# United States Department of Labor
# Employees' Compensation Appeals Board

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| **N.S., Appellant** | ) | |
| **and** | ) | **Docket No. 19-0178** |
| | ) | **Issued: July 23, 2019** |
| **U.S. POSTAL SERVICE, MORGAN NEW YORK PROCESSING & DISTRIBUTION CENTER, New York, NY, Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

### ***JURISDICTION***

On November 5, 2018 appellant filed a timely appeal from an August 23, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

### ***ISSUE***

The issue is whether appellant has met her burden of proof to establish greater than eight percent permanent impairment of her left upper extremity, for which she previously received schedule awards.

[1] 5 U.S.C. § 8101 *et seq.*

## ***FACTUAL HISTORY***

On February 18, 2015 appellant, then a 63-year-old mail hander, filed a traumatic injury claim (Form CA-1) alleging, that on February 17, 2015, she fractured her left wrist when operating a power jack while in the performance of duty.[2] She was holding onto the safety bar of the machine with her left hand when her wrist struck a pillar. X-rays performed on February 17, 2015 demonstrated distal radial comminuted fracture which extended into the radiocarpal joint space as well as avulsion fracture of the ulnar styloid process.

On April 2, 2015 OWCP accepted appellant's claim for a closed fracture of the lower end of the left radius and ulna. It authorized wage-loss compensation beginning April 6, 2015. On July 21, 2015 OWCP entered appellant on the periodic rolls for wage-loss compensation.

On December 21, 2015 Dr. Steven J. Lee, a Board-certified internist, found that appellant had reached maximum medical improvement (MMI) and released her to return to light-duty work lifting no more than five pounds.

On February 9, 2016 OWCP referred appellant, a statement of accepted facts (SOAF), and a list of questions for a second opinion evaluation with Dr. Thomas Nipper, a Board-certified orthopedic surgeon. In his February 17, 2016 report, Dr. Nipper reviewed the SOAF and performed a physical examination. He found tenderness over the distal ulna, limited range of motion (ROM) of the left wrist, and a 30 degree fixed flexion contracture of the proximal interphalangeal (PIP) joints of the left ring and small fingers. Dr. Nipper agreed that appellant had reached MMI. He found that she could work with restrictions of no lifting over 10 pounds with her left hand.

In a note dated March 23, 2016, Dr. Eial Faierman, appellant's attending physician and a Board-certified orthopedic surgeon, noted her history of left wrist fracture on February 17, 2015 and found that she had developed arthritis with joint space narrowing in the radial scapholunate joint. He found loss of ROM including 20 degrees of left wrist extension, 20 degrees of dorsiflexion, and 50 degrees of supination. Dr. Faierman also reported moderate-to-severe tenderness over the distal radius of the radial aspect of appellant's left wrist, mild snuffbox tenderness, and moderate swelling. He diagnosed left post-traumatic osteoarthritis with healed intra-articular displaced distal radius fracture. On June 29, 2016 Dr. Faierman provided additional findings of contractures on the left small finger of 50 to 100 degrees of the PIP joint and 0 to 40 degrees of the distal interphalangeal (DIP) joint. He also reported contractures of the left ring finger of 30 to 100 degrees of the PIP joint and 0 to 30 degrees of the DIP joint. Dr. Faierman diagnosed left wrist fracture with post-traumatic osteoarthritis and provided additional diagnoses including tear of the triangular fibrocartilage, partial thickness tear of the membranous portion of the scapholunate ligament, and fluid within the synovial sheath of the flexor tendons within the carpal tunnel. He noted that appellant had developed left shoulder contracture and received trigger finger injections.

On July 7, 2017 appellant filed a claim for a schedule award (Form CA-7).

[2] Appellant is left-hand dominant.

In a July 10, 2017 development letter, OWCP requested that appellant provide a narrative medical report addressing whether she had attained MMI and a finding as to permanent impairment of the left upper extremity in keeping with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

In a report dated July 19, 2017, Dr. Faierman described appellant's accepted employment incident and medical treatment. He indicated that her left wrist ROM demonstrated 20 degrees of extension, 30 degrees of flexion, 80 degrees of supination, and pronation, as well as 10 degrees of ulnar deviation and 20 degrees of radial deviation. Dr. Faierman noted contractures of the left small finger of 50 to 100 degrees of the PIP joint and 0 to 40 degrees of the DIP joint. He also listed left ring finger contractions of 30 to 100 degrees of the PIP joint and 0 to 30 degrees of the DIP joint. Dr. Faierman found tenderness over the radial aspect of appellant's left wrist. He diagnosed intra-articular left distal radius fracture with post-traumatic osteoarthritis of the radial-scapholunate joint. Dr. Faierman determined that appellant had reached MMI on November 19, 2015. He provided an impairment rating consistent with New York state standards.

On October 10, 2017 Dr. Herbert White, Jr., Board-certified in occupational medicine and district medical adviser (DMA) for OWCP reviewed Dr. Faierman's reports and found that they were insufficient for an impairment rating under the sixth edition of the A.M.A., *Guides* as he had not provided three ROM measurements or a recording of all of appellant's finger ROM measurements. The DMA recommended a second opinion evaluation.

On January 29, 2018 OWCP scheduled a second opinion evaluation with Dr. Jonathan Gross, a Board-certified orthopedic surgeon. In his February 23, 2018 report, Dr. Gross described appellant's accepted employment injury. He reviewed her medical treatment record and applied the fifth edition of the A.M.A., *Guides*[4] to his findings on physical examination. Dr. Gross determined that appellant had 80 degrees of pronation, 70 degrees of supination, 45 degrees of dorsiflexion, 50 degrees of volar flexion, 15 degrees of ulnar deviation, and 20 degrees of radial deviation. He also reported 30 percent flexion contractures in the PIP joints of the ring and small finger which resulted in 84 percent impairment of each of those digits. Dr. Gross diagnosed unresolved left wrist and hand sprain/strain. He also found that appellant had reached MMI.

In a March 31, 2018 report, the DMA applied the sixth edition of the A.M.A., *Guides* to Dr. Gross' physical examination findings. He found that appellant had reached MMI on July 19, 2017. The DMA determined that, based on Table 15-3, page 396, of the A.M.A., *Guides*, her diagnosis was a fracture, class 1, with residual symptoms, consistent objective findings and/or functional loss, with normal motion. He applied a grade modifier functional history (GMFH) of two based on pain with normal activities.[5] Dr. White assigned a grade modifier for physical examination (GMPE) of one due to mild ROM deficits. He further assigned a grade modifier for clinical studies (GMCS) of two due to a torn triangular fibrocartilage ligament. The DMA applied

[3] A.M.A., *Guides*, (6th ed. 2009).

[4] A.M.A., *Guides*, (5th ed. 2000).

[5] A.M.A., *Guides*, 406, Table 15-3.

the net adjustment formula to reach five percent permanent impairment of the left upper extremity based on the diagnosis-based impairment (DBI) of calculating permanent functional impairment.

The DMA found that he was unable to provide a final ROM impairment, as he could not verify that three measurements were taken in accordance with page 464 of the A.M.A., *Guides*. He noted that based on the information provided by Dr. Gross, 45 degrees of flexion was three percent impairment of the left wrist, 50 degrees of extension was three percent impairment of the left wrist, and ulnar deviation of 15 degrees was two percent impairment of the left wrist in accordance with Table 15-32, page 473, of the A.M.A., *Guides*. The DMA found that grade modifier for ROM was one, that the GMFH was two, and that applying the net adjustment formula resulted in eight percent left upper extremity impairment due to loss of ROM. He requested that Dr. Gross provide additional information regarding his ROM measurements to ensure that these figures followed the A.M.A., *Guides* protocols.

With regard to appellant's left fourth and fifth finger impairments, the DMA found that he was unable to provide final ROM impairments based on Dr. Gross' findings. He could not verify that three measurements were taken and noted that all finger motions should have been provided by Dr. Gross. The DMA concurred with Dr. Gross' finding of 84 percent impairment of the left fourth digit and 84 percent impairment of the left fifth digit.

On April 18, 2018 OWCP requested a supplemental report from Dr. Gross. On July 3, 2018 Dr. Gross did not provide additional findings, but indicated that he agreed with the DMA's impairment rating of eight percent of the left wrist.

By decision dated August 23, 2018, OWCP granted appellant a schedule award for eight percent permanent impairment of her left upper extremity.

## ***LEGAL PRECEDENT***

The schedule award provisions of FECA,[6] and its implementing federal regulations,[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[9]

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017).

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class of diagnosis (CDX) condition, which is then adjusted by GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] OWCP procedures provide that, after obtaining all necessary medical evidence, that file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of the permanent impairment specified.[12]

The A.M.A., *Guides* also provide that the ROM impairment method of calculating permanent functional impairment is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable. If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and combined.[13] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[14]

Regarding the application of the ROM or DBI methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides identify a diagnosis that can alternatively be rated by ROM. If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used*."[15] (Emphasis in the original.)

[10] *L.T.*, Docket No. 18-1031 (issued March 5, 2019); A.M.A., *Guides*, 383-492.

[11] A.M.A., *Guides* 411.

[12] *R.B.*, Docket No. 18-1308 (issued January 10, 2019); *P.R.*, Docket No. 18-0022 (issued April 9, 2018); *supra* note 9 at Chapter 2.808.6f (March 2017).

[13] A.M.A., *Guides* 473.

[14] *Id*. at 473-74.

[15] FECA Bulletin No. 17-06 (May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

The Bulletin further advises:

> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.
>
> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[17]

## ***ANALYSIS***

The Board finds that this case is not in posture for decision.

OWCP accepted that appellant sustained closed fracture of the lower end of radius and ulna on the left. It granted her a schedule award for eight percent permanent impairment of her left upper extremity.

The Board finds that OWCP did not follow the procedures outlined in FECA Bulletin No. 17-06. As noted above, FECA Bulletin No. 17-06 provides detailed instructions for obtaining sufficient evidence to conduct a complete impairment evaluation.[18] It indicates that, if the rating physician provides an assessment using the ROM method, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating. FECA Bulletin No. 17-06 further provides that the evaluator should obtain three independent measurements for ROM of each affected body part and that the greatest measurement should be used to determine the extent of impairment.[19] FECA Bulletin No. 17-06 indicates that OWCP should instruct the physician to obtain three independent measurements.[20]

OWCP referred appellant for a second opinion evaluation with Dr. Gross and requested an impairment evaluation in keeping with the A.M.A., *Guides*. In his February 23, 2018 report, Dr. Gross applied an incorrect edition of the A.M.A., *Guides*; he used the fifth edition rather than

[16] *Id.*

[17] *L.T., supra* note 10; *B.R.*, Docket No. 17-0294 (issued May 11, 2018).

[18] *Id.*

[19] *Id.*

[20] *Id.*

the sixth. Furthermore, he did not respond to OWCP's April 18, 2018 request for a supplemental report addressing appellant's ROM of the left wrist, left ring finger, and left small fingers. Dr. Gross also did not provide three independent measurements of the ROM of each impacted member. As OWCP did not obtain a supplemental report from the second opinion physician containing three independent measurements of each ROM in accordance with the procedures set forth in the A.M.A., *Guides* and FECA Bulletin No. 17-06, the Board will remand the case for OWCP to obtain the evidence necessary to complete the rating as described above.[21] Following this and such further development as deemed necessary, OWCP shall issue a *de novo* decision.

## ***CONCLUSION***

The Board finds that this case is not in posture for decision.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the August 23, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: July 23, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

[21] *R.B., supra* note 12; *J.V.*, Docket No. 18-1052 (issued November 8, 2018); *M.C.*, Docket No. 18-0526 (issued September 11, 2018).